



State of Washington  
**VOUCHER DISTRIBUTION**

**Agencies: Please complete only the shaded areas of this form**

Vendor (Agency) Name and Address

Agency Number  
**303**

Location Code  
**GL4**

Agency P.R. or Authorization Number  
**70.168**

Agency Name and Location  
Department of Health  
Office of EMS & Trauma System  
PO Box 47853  
Olympia, WA 98504-7853

Federal ID No or Social Security No (For Reporting Personal Services Contract Payments to IRS)

Received By

Date Received

Use Space Below as Worksheet to Develop or Explain the Goods or Services Purchased. Staple Invoices on Back

**For EMS Prehospital Participation Grants - Trauma Care Funding Act of 1997**

**For participating as a verified prehospital service Amt.  
during the period July 1, 2005 through June 30, 2006.**

**AGENCY NUMBER (LICENSE NUMBER):** \_\_\_\_\_

\*Please note that your agency license must be current in order to be eligible to receive the grant

**THIS A19-2A IS THE ONLY DOCUMENTATION NEEDED FOR PAYMENT.**

Prepared by -			Telephone Number			Date			Agency Approval				Date		
SIGN HERE															
Doc. Date		Pmt Due Date		Current Doc No.		Ref. Doc No.		Vendor Number		Vendor Message		Use Tax		UBI Number	
Ref Doc Suf	Trans Code	M O D	Master Index		Sub Obj	Sub Sub Obj	Org Index	Alloc	Budget Unit	MOS	Project	Sub Proj	Proj Phas	Amount	Invoice Number
			64901450		NZ	9900									FY06

Accounting Approval for Payment									Date			Warrant Total		Invoice Number	
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